HealthfullyU Health Worksheet*

Please list the 5 main health concerns that you would like us to address today.

1. _____
_____
_____
2. _____
_____
_____
3. _____
_____
_____
4. _____
_____
_____
5. _____
_____
_____

Timeline, place any significant health events that occurred to you, your mother, and your grandmother on the timeline. Health events are things like illness, hospital stays, surgeries, traumas, abuse, or just plain not feeling well.

HEALTH HISTORY

Name _____ Date _____

Occupation _____ Age _____ Height _____ Sex _____ Number of Children _____

Marital Status: ❑ Single ❑ Partner ❑ Married ❑ Separated ❑ Divorced ❑ Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit: Date began:

_____ _____

_____ _____

_____ _____

List current health problems for which you are being treated: _____

_____

_____

_____

What types of therapies have you tried for these problem(s) or to improve your health over-all:

❑ diet modification ❑ fasting ❑ vitamins/minerals ❑ herbs ❑ homeopathy ❑ chiropractic ❑ acupuncture ❑ conventional drugs

❑ other _____

Do you experience any of these general symptoms EVERY DAY?

❑ Debilitating fatigue	❑ Shortness of breath	❑ Insomnia	❑ Constipation	❑ Chronic pain/inflammation
❑ Depression	❑ Panic attacks	❑ Nausea	❑ Fecal incontinence	❑ Bleeding
❑ Disinterest in sex	❑ Headaches	❑ Vomiting	❑ Urinary incontinence	❑ Discharge
❑ Disinterest in eating	❑ Dizziness	❑ Diarrhea	❑ Low grade fever	❑ Itching/rash

Current medications (prescription or over-the-counter): _____

_____

_____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):

_____

Outcome _____

_____

_____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): _____

Do you consider yourself: ❑ underweight ❑ overweight ❑ just right Your weight today _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, etc.)?

_____

What are your current health goals: _____

_____

_____

_____

_____

Medical History

- ❑ Arthritis
- ❑ Allergies/hay fever
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Autoimmune disease
- ❑ Blood pressure problems
- ❑ Bronchitis
- ❑ Cancer
- ❑ Chronic fatigue syndrome
- ❑ Carpal tunnel syndrome
- ❑ Cholesterol, elevated
- ❑ Circulatory problems
- ❑ Colitis
- ❑ Dental problems
- ❑ Depression
- ❑ Diabetes
- ❑ Diverticular disease
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Epilepsy
- ❑ Emphysema
- ❑ Eyes, ears, nose, throat problems
- ❑ Environmental sensitivities
- ❑ Fibromyalgia
- ❑ Food intolerance
- ❑ Gastroesophageal reflux disease
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Gout
- ❑ Heart disease
- ❑ Infection, chronic
- ❑ Inflammatory bowel disease
- ❑ Irritable bowel syndrome
- ❑ Kidney or bladder disease
- ❑ Learning disabilities
- ❑ Liver or gallbladder disease (stones)
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological problems (Parkinson's, paralysis)
- ❑ Sinus problems
- ❑ Stroke
- ❑ Thyroid trouble
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Pneumonia
- ❑ Sexually transmitted disease
- ❑ Seasonal affective disorder
- ❑ Skin problems
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Urinary tract infection
- ❑ Varicose veins

Other _____

_____

Medical (Men)

- ❑ Benign prostatic hyperplasia
- ❑ Prostate cancer
- ❑ Decreased sex drive
- ❑ Infertility
- ❑ Sexually transmitted disease

Other _____

_____

Medical (Women)

- ❑ Menstrual irregularities
- ❑ Endometriosis
- ❑ Infertility
- ❑ Fibrocystic breasts
- ❑ Fibroids/ovarian cysts
- ❑ Premenstrual syndrome (PMS)
- ❑ Breast cancer
- ❑ Pelvic inflammatory disease
- ❑ Vaginal infections
- ❑ Decreased sex drive
- ❑ Sexually transmitted disease

Other _____

Date of last GYN exam _____

Mammogram ❑ + ❑ –

PAP ❑ + ❑ –

Form of birth control _____

# of children _____

# of pregnancies _____

❑ C-section _____

Age of first period _____

Date - last menstrual cycle _____

Length of cycle _____ days

Interval of time between cycles _____ days

Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____

- ❑ Surgical menopause
- ❑ Menopause

Family Health History (Parents and Siblings)

- ❑ Arthritis
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Cancer
- ❑ Depression
- ❑ Diabetes
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Heart disease
- ❑ Infertility
- ❑ Learning disabilities
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological disorders (Parkinson's, paralysis)
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Stroke
- ❑ Suicide

Other _____

Health Habits

- ❑ Tobacco:

Cigarettes: #/day _____

Cigars: #/day _____

- ❑ Alcohol:

Wine: #glasses/d or wk _____

Liquor: #ounces/d or wk _____

Beer: #glasses/d or wk _____

- ❑ Caffeine:

Coffee: #6 oz cups/d _____

Tea: #6 oz cups/d _____

Soda w/caffeine: #cans/d _____

Other sources _____

❑ Water: #glasses/d _____

Exercise

- ❑ 5-7 days per week
- ❑ 3-4 days per week
- ❑ 1-2 days per week
- ❑ 45 minutes or more duration per workout
- ❑ 30-45 minutes duration per workout
- ❑ Less than 30 minutes
- ❑ Walk - #days/wk _____
- ❑ Run, jog, other aerobic - #days/wk _____
- ❑ Weight lift - #days/wk _____
- ❑ Stretch - #days/wk _____
- ❑ Other _____

Nutrition & Diet

- ❑ Mixed food diet (animal and vegetable sources)
- ❑ Vegetarian
- ❑ Vegan
- ❑ Salt restriction
- ❑ Fat restriction
- ❑ Starch/carbohydrate restriction
- ❑ The Zone Diet
- ❑ Total calorie restriction

Specific food restrictions:

❑ dairy ❑ wheat ❑ eggs

❑ soy ❑ corn ❑ all gluten

Other _____

Food Frequency

Number of servings per day:

Fruits (citrus, melons, etc.) _____

Dark green or deep yellow/orange vegetables _____

Grains (unprocessed) _____

Beans, peas, legumes _____

Dairy, eggs _____

Meat, poultry, fish _____

Eating Habits

❑ Skip meals - which ones _____

_____

- ❑ One meal/day
- ❑ Two meals/day
- ❑ Three meals/day
- ❑ Graze (small frequent meals)
- ❑ Generally eat on the run
- ❑ Eat constantly whether hungry or not

Current Supplements

- ❑ Multivitamin/mineral
- ❑ Vitamin C
- ❑ Vitamin E
- ❑ EPA/DHA
- ❑ Evening Primrose/GLA
- ❑ Calcium, source _____
- ❑ Magnesium
- ❑ Zinc
- ❑ Minerals, describe _____
- ❑ Friendly flora (acidophilus)
- ❑ Digestive enzymes
- ❑ Amino acids
- ❑ CoQ10
- ❑ Antioxidants (e.g., lutein, resveratrol, etc.)
- ❑ Herbs
- ❑ Homeopathy
- ❑ Protein shakes
- ❑ Superfoods (e.g., bee pollen, phytonutrient blends)
- ❑ Liquid meals (Ensure)

Others _____

_____

I Would Like To:

ENERGY - VITALITY

- ❑ Feel more vital
- ❑ Have more energy
- ❑ Have more endurance
- ❑ Be less tired after lunch
- ❑ Sleep better
- ❑ Be free of pain
- ❑ Get less colds and flu
- ❑ Get rid of allergies
- ❑ Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- ❑ Stop using laxatives and stool softeners
- ❑ Improve sex drive

BODY COMPOSITION

- ❑ Loose weight
- ❑ Burn more body fat
- ❑ Be stronger
- ❑ Have better muscle tone
- ❑ Be more flexible

STRESS, MENTAL, EMOTIONAL

- ❑ Learn how to reduce stress
- ❑ Think more clearly and be more-focused
- ❑ Improve memory
- ❑ Be less depressed
- ❑ Be less moody
- ❑ Be less indecisive
- ❑ Feel more motivated

LIFE ENRICHMENT

- ❑ Reduce my risk of degenerative disease
- ❑ Slow down accelerated aging
- ❑ Maintain a healthier life longer
- ❑ Change from a "treating-illness" orientation to creating a wellness lifestyle

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Natural Health Questionnaire

Name_____ Date_____

Circle/fill in the answers

Stomach burns/aches before/after eating	Y	N	Little to no interest in sex.	Y	N
Undigested food in stools.	Y	N	Erectile dysfunction.	Y	N
E motions effect digestion.	Y	N	Difficulty with orgasm.	Y	N
Abdominal cramping.	Y	N	Depressed, sad, blue.	Y	N
Lots of gas.	Y	N	No interest in friends, family, hobbies.	Y	N
Stool consistency/volume changes.	Y	N	Hopeless/ cry easily.	Y	N
Foul smelling gas/stools.	Y	N	Worried/Nervous/ agitated.	Y	N
Mucous in stools.	Y	N	Scared/ easily startled.	Y	N
Dark Tarry stools	Y	N	Awakened by scary thoughts/dreams	Y	N
Discomfort eating raw fruits/veggies.	Y	N	Angry/ mad/ pent up/ ready to explode	Y	N
Stools: round balls formed loose runs			Little annoyances get you upset	Y	N
Bowel movements ____ /mo. /week /day.			Prone to loud emotional outbursts.	Y	N
Feel toxic.	Y	N	Angry when told what to do.	Y	N
Bitter reflux.	Y	N	Bone pain.	Y	N
Discomfort eating oils/fats.	Y	N	Morning stiffness.	Y	N
Stool color changes clay/brown/green.	Y	N	Joint swelling/stiffness.	Y	N
Beer belly.	Y	N	Muscles stiff/sore/cramp/spasm.	Y	N
Rashes.	Y	N	Restless legs.	Y	N
Strong body odor.	Y	N	Incomplete bladder emptying.	Y	N
Easily chilled.	Y	N	Smaller urine stream.	Y	N
Cold hands/feet.	Y	N	Dripping after urination.	Y	N
Tired/sluggish.	Y	N	Start & stop many time to urinate.	Y	N
Thinning hair.	Y	N	**Women 3 -14 days before menses**		
No energy.	Y	N	Emotional/ angry/ irritable/restless.	Y	N
Unexplained weight gain.	Y	N	Crave sweets.	Y	N
Can't lose weight.	Y	N	Bloating/breast tender/swollen.	Y	N
Exhausted.	Y	N	Thin watery cervical mucous.	Y	N
Belly fat.	Y	N	Discharge from nipples.	Y	N
Tire easily with minor exertion/stress.	Y	N	**During Menses**		
Acne.	Y	N	Spotting with scant flow.	Y	N
Female facial/abdominal/chest hair.	Y	N	Clotting/heavy flow.	Y	N
Manboobs.	Y	N	Cramping/ bloating.	Y	N
Crave fatty/salty food.	Y	N	Nausea/Vomiting.	Y	N
Dizzy on rising.	Y	N	Headaches/migraines.	Y	N
Very tired shortly after eating.	Y	N	Painful intercourse.	Y	N
Always thirsty.	Y	N	Abnormal/offensive vaginal discharge.	Y	N
Awake & restless.	Y	N	Bleeding between periods or long periods.	Y	N
Poor memory/confused/forgetful.	Y	N	Infertility.	Y	N
Anxiety, fidgety	Y	N	Irregular or infrequent periods.	Y	N
Crave sugar.	Y	N	Vaginal burning/dryness.	Y	N
Frequent urination.	Y	N	Bleeding after intercourse.	Y	N
Itchy all over.	Y	N	Fluctuating sense of well being.	Y	N

Hot flashes. Y N
Night Sweats. Y N
Chills/cold hands or feet. Y N
Brain Fog, difficulty concentrating. Y N
Sleep disturbances. Y N

History of broad spectrum antibiotic use. Y N
History of chronic stress. Y N
History of steroid use. Y N
Crave and eat sweets. Y N
Crave & eat breads. Y N
History of prostatitis or vaginitis. Y N
History of oral birth control use. Y N
Aeormatic smells bother you. Y N
History of athlete's feet or ringworm. Y N
History of yeast or fungal infection. Y N
Symptoms worse on damp days. Y N
Tobacco or any smoke really others you. Y N

Dietary Diary (foods & liquids)

Day_____ Time Awake _____ 1st Meal _____
Morning:

Midday:

Evening:

Day_____ Time Awake _____ 1st Meal _____
Morning:

Midday:

Evening:

Day_____ Time Awake _____ 1st Meal _____
Morning:

Midday:

Evening:

Day_____ Time Awake _____ 1st Meal _____
Morning:

Midday:

Evening:

Day_____ Time Awake _____ 1st Meal _____
Morning:

Midday:

Evening:

Day_____ Time Awake _____ 1st Meal _____
Morning:

Midday:

Evening:

Day_____ Time Awake _____ 1st Meal _____
Morning:

Midday:

Evening: